

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004171</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH NORTH HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>11700 N MERIDIAN ST CARMEL, IN 46032</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This was a State hospital complaint investigation.</p> <p>Complaint: #IN00159786 Unsubstantiated: Lack of sufficient evidence.</p> <p>Facility Number: 004171</p> <p>Survey Date: 05/06/2015</p> <p>Indiana University Health North Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules.</p> <p>QA: cjl 05/14/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE